CALIFORNIA SCDD
State Council on Developmental Disabilities

Regional Advisory Committee Agenda

Date	Tuesday, July 26, 2016
Time	11:00 a.m. – 1:00 p.m.*
Location	SCDD Sacramento Office 2033 Howe Avenue, Ste. 160, Sacramento, CA 95825 (916) 263-3085

Pursuant to Government code Sections 11123.1 and 11125(f), individuals with disabilities who require accessible alternative formats of the agenda and related meeting materials and/or auxiliary aids/services to participate in this meeting should contact Sonya Bingaman at (916) 263-3085 or by email to: sonya.bingaman@scdd.ca.gov. Requests must be received by 5:00 pm, July 18, 2016.

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1) Call to Order, Chairperson, Chris Hickey (FA) — 11:00 a.m.
   a. Welcome new RAC Members & Introductions
2) Approval of RAC Agenda, Chris Hickey (FA) — (action)
3) Approval of RAC Minutes from May 24, 2016, Chris Hickey (FA) — (action)
4) Brief reports from RAC members on issues in their counties
5) Public Comment Period

   This item is for members of the public only to provide comments and/or present information to the RAC on matters not on the agenda. Each person will be afforded up to three minutes to speak. Written requests, if any, will be considered first. The RAC will provide a public comment period, not to exceed a total of seven minutes, for public comment prior to action on each agenda item.
6) Regional Center Report, Peter Tiedemann — (5 minutes)
7) Statewide Self-Advocacy Network (SSAN) Report, Lisa Cooley (SA) — (5 minutes)
8) Regional Office Manager's Report & Discussion, Sonya Bingaman
   a. Grant Cycle 39 Update
   b. Budget Update (State of CA)
   c. Self-Determination (SDAC & SSDAC)
   d. Outreach
   e. Conferences
   f. Trainings
9) Community Program Specialist Report, Kathy Brian
   a. NCI Child Family Survey Update
   b. Other activities

10) Presentation on **HCBS (Home and Community Based Services) Settings Rules for California**, Sonya Bingaman

   a. RAC input, comments, concerns, questions (Chris Hickey) (action)

11) Presentation on **Accommodations to Successfully Attend College, David Nisson** (SA)
http://stories.ucdavis.edu/stories/students/nisson.html

12) Proposed Agenda items for next meeting, Chris Hickey (FA) (action)

13) Next regular RAC meeting is September 27, 2016, 11 a.m. – 1 p.m.

14) Adjournment – Chris Hickey (FA) 1:00 p.m.

CALIFORNIA SCDD
State Council on Developmental Disabilities

Regional Advisory Committee

Regional Advisory Committee – Sacramento Office
Minutes
May 24, 2016
Unapproved

Members Present	Members Absent	Other Attending
Elaine Linn (FA)	Christine Hickey (FA)	Sandra Smith (FA) Council Member
Robert Rogers (SA)		Fernando Cibrian
Jane Taylor (FA)		Rachael Frederick-Vijay
Donnell Kenworthy (FA)		Tony Biondi (SA)
Karen Mulvaney (FA)		Colleen Moss
Tyler Busselen (SA)		Lisa Cooley (SA)
Nancy Esparza (FA)		Sheryl Ledford
Tyson Whitman (SA)		Eloise Dixon
Brandy Boyd		Peter Tiedemann
		Kathy Brian
		Sonya Bingaman

1) Call to Order, Chairperson, Elaine Linn (FA) 11:00 a.m.
Welcome & Introductions

2) Approval of RAC Agenda, Elaine Linn (FA) (action)
Donnell Kenworthy gave motion to approve; Jane Taylor seconded.

3) Approval of RAC Meeting Minutes from January 26, 2016, Elaine Linn (FA) (action)

Donnell Kenworthy gave motion to approve; Robert Rogers seconded.

4) Brief reports from RAC members on issues in their counties

Robert Rogers, Yuba City: Reported the Supported Life Self-Advocacy conference was a success. He gave a presentation with the assistance of Sonya Bingaman, SCDD Manager, on Emergency Preparedness. He stated over 100 people attended their session. He reported to learn a lot from people who attended from the states, Hawaii, Arizona and Nevada. Mr. Rogers thanked the SCDD Sacramento Regional Office for their sponsoring his attendance at the conference. SCDD Sacramento Regional Office was a co-sponsor of the Self-Advocacy Conference as well.

Karen Mulvaney, El Dorado: Reported she attended the California Health and Wellness forum along with Sonya Bingaman. She shared it was a great opportunity to network as El Dorado has over 19,000 members, noting it has the largest number of participants.

Jane Taylor, Nevada County: She reported that there are no dentists in the area who take Denti Cal.

5) Public Comment Period

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Karen Mulvaney shared an update on the Home and Community Based Services (HCBS) Transition Meeting, stating DDS is working on a timeline for deliverables and transition implementation.

6) Rachael Frederick –Vigary, Mutual Housing Presentation (5 minutes)

Fernando Cibrian, Director and Rachael Frederick-Vigary gave a presentation on Mutual Housing. Development of this low-income housing is occurring in Sacramento, Davis and Woodland. Candidates who qualify for this housing can be people with developmental disabilities, mental health issues, chemical dependency, and homelessness or at risk of homelessness. Additional criteria include people who are exiting a skilled nursing facility or congregate living situation. www.mutualhousing.com

7) Regional Center Report, Peter Tiedemann

Pete Tiedemann discussed the survey ACRC sent to vendors, a random sample, as they have 800 and need a statistically valid sample so he is encouraging vendors to complete the survey and return to ACRC.

8) SSAN Report, Lisa Cooley

Lisa Cooley reported on June 8-9, 2016 a Statewide Self-Advocacy Network meeting took place.

9) Regional Office Manager's Report & Discussion Sonya Bingaman

a. Grant Cycle 39 Update
Our catchment area voted on the following 2 topics: Self-Advocacy and Employment. The grants are out to address these 2 topics, they will be reviewed and begin in October.

b. Budget Update (State of CA)
Follow updates on Marty Omoto's CDCAN

c. Self-Determination (SDAC & SSDAC)
Currently DDS is working on answering 80 questions about the HCBS settings rules. This will be submitted however while this needs to correlate with the HCBS settings rules and Transition Plan, it will be a process as there are 110,000 people on the waiver. Tennessee has an approved Transition Plan, as they only support 6,000 people.

d. Outreach by SCDD Sacramento Regional Office –
March-May 2016

- Self-Determination
  - Workgroup Meeting
  - Advisory Committee Meeting
  - SCDD staff trailed 20 self-advocates about Self Determination
- Community Outreach
  - SELPA Meetings – Placer, El Dorado Counties
  - Disability Day/Sac City Community College
  - ACRC Purchase of Service Expenditure Forum
  - Youth Leadership Forum – Employment
  - ACRC Residential Vendor Forum
  - ACRC Adult Day/Employment Vendor Forum
  - Housing Now board meeting
  - Sonoma DC Family/Provider meeting
  - Emergency Training Planning collaboration with SCDD offices
  - Think Transition collaboration with the MIND Institute
  - Transition Community Outreach – Rancho Cordova

- Self-Advocacy – PAC Regional Planning/Meeting
- Assistive Technology Fair at MIND Institute
- Connected regular ed students with DDSO Employment + participants
- ACRC Consumer Advisory Committee
- Provided information at the Career and Employment Fair (SAHRA/UC Davis)
- California Health and Wellness Community Connections Forum – El Dorado Co.
- Self-Advocacy Conference SCDD Resource Table
- Self-Advocacy Conference session assistance to consumers on:
  - Medication Presentation, Emergency Preparation, Public Speaking Self-Determination
- ACRC Employment Committee
- Medi-Cal Dental Advisory Committee
- Kids day Information Fair – Rancho Cordova
- DDSO Adult day program
  - Visit and Tour
  - Rights Training for consumers
- Business Advisory Council (BAC) Committee participation
  - Event at the Universal Technical Institute
- HCBS Settings Rules Forum

- Conferences
  - Person Centered Practices Conference (The Learning Community)
  - Family Voices Health Summit Conference

- E-Blasts
  - Job Fair
  - Bullying Training
  - Family Voices Health Summit (CCS)

- Calls for Assistance
  - 15 calls for general assistance
  - 7 calls for Special Education assistance

10) Community Program Specialist Report, Kathy Brian

a. NCI Child Family Survey Update:
SCDD Sacramento Regional Office has received 984 surveys to date.

b. Longitudinal Study and Movers Study
SCDD staff received a random sample of 12 consumers and is conducting visits.

c. Employment and BAC activities

The Business Advisory Council continues to network with job developers and prospective employers to identify employer needs and assists to seek employment for people with ID/DD.

11) Presentation on **Lessons learned from Educational Inclusion and What It Means for all Children, Nelia Nunes** (FA)
Presentation by Nelia Nunes, parent of a 3rd grade daughter and her mission to full inclusion into the classroom.

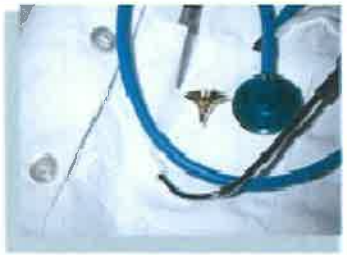
12) Proposed Agenda items for next meeting, Elaine Linn (FA) (action)
- HCBS Settings rules

13) Next regular RAC meeting is July 26, 2016, 11 a.m. – 1 p.m.

14) Adjournment – Elaine Linn (FA) 1:30 p.m.

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Final Rule
Medicaid HCBS



Disabled and Elderly Health Programs Group
Center for Medicaid and CHIP Services

Presented to
SCDD Sacramento Regional Advisory Committee
July 26, 2016

CALIFORNIA SCDD
State Council on Developmental Disabilities

Intent of the Final Rule

- To ensure that individuals receiving long-term services and supports through home and community based service (HCBS) programs under the 1915(c), 1915(i) and 1915(k) Medicaid authorities have full access to benefits of community living and the opportunity to receive services in the most integrated setting appropriate

- To enhance the quality of HCBS and provide protections to participants

Home and Community-Based Setting Requirements

- The home and community-based setting requirements establish an outcome oriented definition that focuses on the nature and quality of individuals' experiences
- The requirements maximize opportunities for individuals to have access to the benefits of community living and the opportunity to receive services in the most integrated setting

Home and Community-Based Setting Requirements

The final rule establishes:

- Mandatory requirements for the qualities of home and community-based settings including discretion for the Secretary to determine other appropriate qualities
- Settings that are not home and community-based
- Settings presumed not to be home and community-based
- State compliance and transition requirements

Home and Community-Based Setting Requirements

The Home and Community-Based setting:

- Is integrated in and supports access to the greater community
- Provides opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources
- Ensures the individual receives services in the community to the same degree of access as individuals not receiving Medicaid home and community-based services

Home and Community-Based Setting Requirements

- Is selected by the individual from among setting options, including non-disability specific settings and an option for a private unit in a residential setting
  - Person-centered service plans document the options based on the individual's needs, preferences; and for residential settings, the individual's resources

Home and Community-Based Setting Requirements

- Ensures an individual's rights of privacy, dignity, respect, and freedom from coercion and restraint
- Optimizes individual initiative, autonomy, and independence in making life choices
- Facilitates individual choice regarding services and supports, and who provides them

Home and Community-Based Setting Requirements for Provider-Owned or Controlled Residential Settings

Additional requirements:

- Specific unit/dwelling is owned, rented, or occupied under legally enforceable agreement
- Same responsibilities/protections from eviction as all tenants under landlord tenant law of state, county, city or other designated entity
- If tenant laws do not apply, state ensures lease, residency agreement or other written agreement is in place providing protections to address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law

Home and Community-Based Setting Requirements for Provider-Owned or Controlled Residential Settings

- Each individual has privacy in their sleeping or living unit
- Units have lockable entrance doors, with the individual and appropriate staff having keys to doors as needed
- Individuals sharing units have a choice of roommates
- Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement
- Individuals have freedom and support to control their schedules and activities and have access to food any time
- Individuals may have visitors at any time
- Setting is physically accessible to the individual

Settings that are NOT Home and Community-Based

- Nursing facility
- Institution for mental diseases (IMD)
- Intermediate care facility for individuals with intellectual disabilities (ICF/IID)
- Hospital

Settings PRESUMED NOT to Be Home and Community-Based

- Settings in a publicly or privately-owned facility providing inpatient treatment
- Settings on grounds of, or adjacent to, a public institution
- Settings with the effect of isolating individuals from the broader community of individuals not receiving Medicaid HCBS

Settings PRESUMED NOT to Be Home and Community-Based-Heightened Scrutiny

These settings (slide 18) may NOT be included in states' 1915(c), 1915(i) or 1915(k) HCBS programs unless:

- A state submits evidence (including public input) demonstrating that the setting does have the qualities of a home and community-based setting and NOT the qualities of an institution; AND
- The Secretary finds, based on a heightened scrutiny review of the evidence, that the setting meets the requirements for home and community-based settings and does NOT have the qualities of an institution

1915(i) State Plan HCBS Benefit

The final rule implements the laws and requires the state to establish -

- Needs-based criteria and evaluation
- Independent assessment for each individual determined to be eligible for the benefit
- Person-centered service plan
- Provider qualifications
- Definition of individual's representative
- Self-directed services
- State responsibilities and quality improvement

1915(i) State Plan HCBS Benefit - Provider Qualifications Requirements

The state defines -

- Standards for agency and individual providers
- Standards for agents conducting evaluations, assessment, and service plan development
- Conflict of interest standards to assure independence (Note: Conflict of interest standards apply to public and private individuals and entities)

What questions, concerns, input, or comments do you have regarding HCBS implementation in California?

CALIFORNIA SCDD
State Council on Developmental Disabilities

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Room 352-G
200 Independence Avenue, SW
Washington, DC 20201

CENTERS FOR MEDICARE & MEDICAID SERVICES
OFFICE OF COMMUNICATIONS

FACT SHEET

FOR IMMEDIATE RELEASE
January 10, 2014

Contact: CMS Media Relations
(202) 690-6145

Home and Community Based Services

Overview

The final rule addresses several sections of Medicaid law under which states may use federal Medicaid funds to pay for home and community-based services (HCBS). The rule supports enhanced quality in HCBS programs, adds protections for individuals receiving services. In addition, this rule reflects CMS' intent to ensure that individuals receiving services and supports through Medicaid's HCBS programs have full access to the benefits of community living and are able to receive services in the most integrated setting. Highlights of this final rule include:

- Provides implementing regulations for section 1915(i) State Plan HCBS, including new flexibilities enacted under the Affordable Care Act to offer expanded HCBS and to target services to specific populations;
- Defines and describes the requirements for home and community-based settings appropriate for the provision of HCBS under section 1915(c) HCBS waivers, section 1915(i) State Plan HCBS and section 1915(k) (Community First Choice) authorities;
- Defines person-centered planning requirements across the section 1915(c) and 1915(i) HCBS authorities;
- Provides states with the option to combine coverage for multiple target populations into one waiver under section 1915(c), to facilitate streamlined administration of HCBS waivers and to facilitate use of waiver design that focuses on functional needs.
- Allows states to use a five-year renewal cycle to align concurrent waivers and state plan amendments that serve individuals eligible for both Medicaid and Medicare, such as 1915(b) and 1915(c).
- Provides CMS with additional compliance options beyond waiver termination for 1915(c) HCBS waiver programs.

Key Provisions of the Final Rule

1915(c) Home and Community-Based Waivers

The final rule amends the regulations for the 1915(c) HCBS waiver program, authorized under section 1915(c) of the Social Security Act (the Act), in several important ways designed to improve the quality of services for individuals receiving HCBS. Specifically, it establishes requirements for home and community-based settings in Medicaid HCBS programs operated under sections 1915(c), 1915(i), and 1915(k) of the Act, defines person-centered planning requirements, provides states with the option to combine multiple target populations into one waiver to facilitate streamlined administration of HCBS waivers, clarifies the timing of amendments and public input requirements when states propose modifications to HCBS waiver programs and service rates, and provides CMS with additional compliance options for HCBS programs. For more detail, please refer to the 1915(c) fact sheet at http://www.medicaid.gov/HCBS.

Section 1915(i) Home and Community-Based State Plan Option

The final rule implements the section 1915(i) HCBS state plan option, including new flexibilities enacted under the Affordable Care Act that offer states the option to provide expanded home and community-based services and to target services to specific populations. In addition, the final rule establishes requirements for home and community-based settings in Medicaid HCBS programs operated under sections 1915(c), 1915(i), and 1915(k) of the Act. For more detail, please refer to the 1915(i) fact sheet at http://www.medicaid.gov/HCBS.

Section 2601 of the Affordable Care Act: Five Year Period for Certain Demonstration Projects and Waivers

To simplify administration of the program for states, this final rule provides a five-year approval or renewal period for demonstration and waiver programs in which a state serves individuals who are dually eligible for Medicare and Medicaid benefits. This provision allows states to use a five year renewal cycle to align concurrent waivers that serve individuals eligible for both Medicaid and Medicare, such as 1915(b) and 1915(c).

Home and Community-Based Settings Requirements

The final rule establishes requirements for home and community-based settings in Medicaid HCBS programs operated under sections 1915(c), 1915(i), and 1915(k) of the Act. The rule creates a more outcome-oriented definition of home and community-based settings, rather than one based solely on a setting's location, geography, or physical characteristics. The regulatory changes will maximize the opportunities for HCBS program participants to have access to the benefits of community living and to receive services in the most integrated setting and will effectuate the law's intention for Medicaid home and community-based services to provide alternatives to services provided in institutions. For more detail, please refer to the HCBS Settings fact sheet at http://www.medicaid.gov/HCBS.

The final rule includes a provision requiring states offering HCBS under existing state plans or waivers to develop transition plans to ensure that HCBS settings will meet final rule's requirements. New 1915(c) waivers or 1915(i) state plans must meet the new requirements to be approved. For currently approved 1915(c) waivers and 1915(i) state plans, states will need to evaluate the settings currently in their 1915(c) waivers and 1915(i) state plan programs and, if there are settings that do not meet the final regulation's home and community-based settings requirements, work with CMS to develop a plan to bring their program into compliance. The public will have an opportunity to provide input on states' transition plans. CMS expects states to transition to compliance in as brief a period as possible and to demonstrate substantial progress toward compliance during any transition period. CMS will afford states a maximum of a one year period to submit a transition plan that provides for the delivery of HCBS services within settings meeting the final rule's requirements, and CMS may approve transition plans for a period of up to five years, as supported by an individual state's circumstances.

States submitting a 1915(c) waiver renewal or waiver amendment within the first year after the effective date of the rule may need to develop a transition plan to ensure that specific waiver or state plan meets the settings requirements. Within 120 days of the submission of that 1915(c) waiver renewal or waiver amendment the state needs to submit a plan that lays out timeframes and benchmarks for developing a transition plan for all the state's approved 1915(c) waiver and 1915(i) HCBS state plan programs. CMS will be issuing future guidance to provide the details regarding requirements for transition plans.

Person-Centered Planning

In this final rule, CMS specifies that service planning for participants in Medicaid HCBS programs under section 1915(c) and 1915(i) of the Act must be developed through a person-centered planning process that addresses health and long-term services and support needs in a manner that reflects individual preferences and goals. The rules require that the person-centered planning process is directed by the individual with long-term support needs, and may include a representative whom the individual has freely chosen and others chosen by the individual to contribute to the process. The rule describes the minimum requirements for person-centered plans developed through this process, including that the process results in a person-centered plan with individually identified goals and preferences. This planning process, and the resulting person-centered service plan, will assist the individual in achieving personally defined outcomes in the most integrated community setting, ensure delivery of services in a manner that reflects personal preferences and choices, and contribute to the assurance of health and welfare. CMS will provide future guidance regarding the process for operationalizing person-centered planning in order for states to bring their programs into compliance.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

January 10, 2014

Fact Sheet: Summary of Key Provisions of the Home and Community-Based Services (HCBS) Settings Final Rule
(CMS 2249-F/2296-F)

This final rule establishes requirements for the qualities of settings that are eligible for reimbursement for the Medicaid home and community-based services (HCBS) provided under sections 1915(c), 1915(i) and 1915(k) of the Medicaid statute. Over the past five years, CMS has engaged in ongoing discussions with stakeholders, states and federal partners about the qualities of community-based settings that distinguish them from institutional settings. As part of this stakeholder engagement, CMS issued an Advanced Notice of Proposed Rule Making (ANPRM) and various proposed rules relating to home and community-based services authorized by different sections of the Medicaid law, including 1915(c) HCBS waivers, 1915(i) State Plan HCBS and 1915(k) Community First Choice State Plans. CMS' definition of home and community-based settings has benefited from and evolved as a result of this stakeholder engagement.

In this final rule, CMS is moving away from defining home and community-based settings by "what they are not," and toward defining them by the nature and quality of individuals' experiences. The home and community-based setting provisions in this final rule establish a more outcome-oriented definition of home and community-based settings, rather than one based solely on a setting's location, geography, or physical characteristics. The changes related to clarification of home and community-based settings will maximize the opportunities for participants in HCBS programs to have access to the benefits of community living and to receive services in the most integrated setting and will effectuate the law's intention for Medicaid HCBS to provide alternatives to services provided in institutions.

Overview of the Settings Provision

The final rule requires that all home and community-based settings meet certain qualifications. These include:

- The setting is integrated in and supports full access to the greater community;
- Is selected by the individual from among setting options;
- Ensures individual rights of privacy, dignity and respect, and freedom from coercion and restraint;
- Optimizes autonomy and independence in making life choices; and
- Facilitates choice regarding services and who provides them.

The final rule also includes additional requirements for provider-owned or controlled home and community-based residential settings. These requirements include:

- The individual has a lease or other legally enforceable agreement providing similar protections;

- The individual has privacy in their unit including lockable doors, choice of roommates and freedom to furnish or decorate the unit;
- The individual controls his/her own schedule including access to food at any time;
- The individual can have visitors at any time; and
- The setting is physically accessible.

Any modification to these additional requirements for provider-owned home and community-based residential settings must be supported by a specific assessed need and justified in the person-centered service plan.

The final rule excludes certain settings as permissible settings for the provision of Medicaid home and community-based services. These excluded settings include nursing facilities, institutions for mental disease, intermediate care facilities for individuals with intellectual disabilities, and hospitals. Other Medicaid funding authorities support services provided in these institutional settings.

The final rule identifies other settings that are presumed to have institutional qualities, and do not meet the threshold for Medicaid HCBS. These settings include those in a publicly or privately-owned facility that provides inpatient treatment; on the grounds of, or immediately adjacent to, a public institution; or that have the effect of isolating individuals receiving Medicaid-funded HCBS from the broader community of individuals not receiving Medicaid-funded HCBS. If states seek to include such settings in Medicaid HCBS programs, a determination will be made through heightened scrutiny, based on information presented by the state demonstrating that the setting is home and community-based and does not have the qualities of an institution. This process is intended to be transparent and includes input and information from the public. CMS will be issuing future guidance describing the process for the review of settings subject to heightened scrutiny through either the transition plan process (for settings already in states' HCBS programs) or the HCBS waiver review processes (for settings states seek to add to their HCBS programs).

The final rule includes a transitional process for states to ensure that their waivers and state plans meet the HCBS settings requirements. New 1915(c) waivers or 1915(i) state plans must meet the new requirements to be approved. For currently approved 1915(c) waivers and 1915(i) state plans, states must evaluate the settings currently in their 1915(c) waivers and 1915(i) state plan programs and, if there are settings that do not fully meet the final regulation's home and community-based settings requirements, work with CMS to develop a plan to bring their program into compliance. The public will have an opportunity to provide input on states' transition plans. CMS expects states to transition to the new settings requirements in as brief a period as possible and to demonstrate substantial progress during any transition period. CMS will afford states a maximum of a one year period to submit a transition plan for compliance with the home and community-based settings requirements of the final rule, and CMS may approve transition plans for a period of up to five years, as supported by individual states' circumstances, to effectuate full compliance.

States submitting a 1915(c) waiver renewal or waiver amendment within the first year of the effective date of the rule may need to develop a transition plan to ensure that specific waiver or state plan meets the settings requirements. Within 120 days of the submission of that 1915(c) waiver renewal or waiver amendment, the state needs to submit a plan that lays out timeframes and benchmarks for developing a transition plan for all the state's approved 1915(c) waiver and 1915(i) HCBS state plan programs. CMS will work closely with states as they consider how to best implement these provisions and will be issuing future guidance on requirements for transition plans.

Changes in the Final Rule

The final rule clarifies several major areas of confusion and concern expressed by some commenters and stakeholders engaged throughout the processes of rulemaking regarding the requirements for home and community-based settings. While CMS' responses to the specific comments are contained in the preamble to the final rule, below is a summary of the areas of the rule that received the most feedback and the changes in the final rule that address those comments:

- **Disability specific complex.** The proposed rule included "disability specific complex" in the list of settings presumed not to be home and community-based settings. Comments on the proposed rules suggested that the phrase "disability specific complex" had multiple meanings, and the continued use of the phrase could have unintended adverse impacts on affordable housing options. To avoid those consequences, CMS eliminated the use of the phrase from the final rule. The final rule includes the following language on other settings: "any other setting that has the effect of discouraging integration of individuals from the broader community…"

- **Rebuttable presumption.** The proposed rule indicated that CMS would exercise a "rebuttable presumption" that certain settings are not home and community-based. CMS has removed this phrase from the final rule and clarified in the final rule that certain settings are presumed to have institutional characteristics and will be subjected to heightened scrutiny if states seek to include these settings in their HCBS programs. The rule allows the state to present evidence to CMS that the setting is actually home and community-based in nature and does not have the qualities of an institution. CMS will consider input from stakeholders, as well as its own reviews, in applying heightened scrutiny. This process will require the state to solicit public input.

- **Choice of provider in provider owned or controlled settings.** The final rule clarifies that when an individual chooses to receive home and community-based services in a provider owned or controlled setting where the provider is paid a single rate to provide a bundle of services, the individual is choosing that provider, and cannot choose an alternative provider, to deliver all services that are included in the bundled rate. For any services that are not included in the bundled rate, the individual may choose any qualified provider, including the provider who controls or owns the setting if the provider offers the service separate from the bundle. For example, if a residential program provides habilitation connected with daily living and on-site supervision under a bundled rate, an individual is choosing the residential provider for those two services when he or she chooses the residence. The individual has free choice of providers for any other services in his or her service plan, such as employment services and other community supports.

- **Private rooms and roommate choice.** The final rule clarifies that states, as opposed to individual providers, have the responsibility for ensuring that individuals have options available for both private and shared residential units within HCBS programs. The rule further clarifies that an individual's needs, preferences and resources are relevant to his/her options for shared versus private residential units. Provider owned or operated residential settings will be responsible to facilitate individuals having choice regarding roommate selection within a residential setting.

- **Application of home and community-based settings requirements to non-residential settings.** CMS has clarified that the rule applies to all settings where HCBS are delivered, not just to residential settings. CMS will be providing additional information about how states should apply the standards to non-residential settings, such as day program and pre-vocational training settings.

CALIFORNIA SCDD

Disability Rights California

California's protection & advocacy system

June 15, 2016

Honorable Chris Holden
California State Assembly
Capitol Building, Room 3152
Sacramento, CA 95814

RE: AB 1715

Dear Assembly Member Holden:

We write in opposition to AB 1715. The bill is scheduled to be heard in the Senate Business Professions and Economic Development Committee on June 27, 2016. We support high quality behavioral health services with appropriate professional standards for individuals with autism and other developmental disabilities. Unfortunately, this bill, in its current form, falls short of improving service quality, may limit access to services, and will likely increase the cost of services. AB 1715: 1) duplicates procedures already in place for Board Certified Behavior Analyst (BCBA) certification; 2) limits access to other evidence-based practices that are not based on the principles of applied behavior analysis; 3) severely limits providers' ability to provide necessary transdisciplinary care; 4) limits access to quality care to underserved populations; 5) limits access to quality inclusive community settings; 6) limits parents' ability to use applied behavior analysis; 7) will limit treatment research for individuals with Autism Spectrum Disorder (ASD); 8) favors professionals who provide behavior analytic treatments on the California Board of Psychology. Our specific concerns and recommendations are discussed below.

1. **The bill duplicates procedures already in place for BCBA certification.** The National Behavior Analyst Certification Board (BACB) has a procedure in place for verifying the training, practicum/supervised fieldwork experience and qualifications of their

BCBAs and Board Certified Associate Behavior Analysts (BCABAs). The BACB has ethical standards and disciplinary procedures in place for professional and ethical violations. Requiring a license creates a burden to potentially qualified providers of service as providers will need to pay for both the current certification as well as the proposed new licensing fees.

2. **The bill limits access to other evidence-based practices that are not based on the principles of applied behavior analysis.** Applied Behavior Analysis (ABA) is one broad methodology under which many evidence-based practices fall. There are additional evidence based practices developed outside of the field of ABA. An increasing number of interventions have some empirical support, including developmental social-pragmatic (DSP). We are concerned payors will limit evidence-based practice for ASD to ABA services provided only by licensed behavior analysts. If we are forced to develop new legislation each time a new innovative practice is established, we will negatively impact access to treatment.

3. **The bill severely limits providers' ability to provide the necessary transdisciplinary care needed for individuals with ASD.** The definition of the "practice of behavior analysis" in the bill is narrow, not including other evidence-based practices for ASD, and includes strategies often used in other disciplines that may limit their ability to practice effectively. Many evidence-based comprehensive models also include developmental, visual, augmentative communication and other strategies that require a transdisciplinary team. Having an expert in behavior analysis, such as a Board Certified Behavior Analysts (BCBAs) is essential to these programs. However, requiring licensure of assistants or technicians working in these programs limits the types of treatment methods other professionals and paraprofessionals can implement in these programs. Additional medically necessary services for many children with ASD include Speech and Language Therapy, Occupational Therapy, Mental Health Counseling and Parent Training/Coaching. In short, the definition of behavior analysis in the bill may be too narrow to include all of the evidence-based practices that are effective for ASD.

4. **The bill limits access to quality care to underserved populations and will increase costs.** Requiring licensure for all levels of service

providers will increase the cost of care and reduce the number of trained and available professionals. There are already long waiting lists for ABA services. Access will be reduced further if all paraprofessional staff need licensure. Licensure will also greatly increase costs because providers of applied behavior analysis services will not be able to continue the same level of care at the reimbursement rates currently provided by the Regional Center and Medi-Cal. Only children with private insurance, or families with high resources, will be able to access intensive behavioral intervention.

5. **The bill limits access to quality inclusive community services.** Many individuals with ASD are included in typical activities, like preschool, sports, and camp programs in the community. This often necessitates having a trained behavior analyst develop a program and teach community providers to implement behavior plans to allow participation in inclusive activities. This bill appears to make it unethical for licensed behavior analysts to provide this type of supervision to non-licensed staff such as preschool teachers, daycare providers and other community supports.

6. **The bill limits parents' ability to use applied behavior analysis.** The bill exempts parents from licensure if they "act under the direction of a licensed behavior analyst." Parents often receive very short term education and then work with their children using ABA strategies on an ongoing basis. Parents can learn to use these strategies competently. It is unclear how parents can be required to only use ABA strategies under supervision, especially when parent training services are not often funded.

7. **The bill will limit treatment research for individuals with ASD.** The bill limits research that includes the direct delivery of behavior analysis services. Broadly defined this can include treatment developers in a variety of fields who use combined models (which are evidence-based) or ABA models developed prior to the requirement for licensure. Some of the main evidence-based practices for ASD were developed at public universities in California by top scientists who do not meet the requirements for licensure.

8. **The bill favors professionals who provide behavior analytic treatments on the California Board of Psychology**. No other specific treatment methodology has a guaranteed member on the

Board of Psychology. Only a subset of behavior analysts are psychologists.

We do not believe this bill is necessary. If it moves forward, to address the above concerns, we recommend:

a. Licensure includes only the Behavior Analyst level and not the assistant or intern levels to ensure continued transdisciplinary practice and access to community programs under the supervision of a qualified Behavior Analyst in collaboration with other professionals and paraprofessionals.

b. Include treatments defined as evidence-based by the National Autism Center (NAC) and National Professional Development Center on Autism (NPDC), most of which are based on the principles of applied behavior analysis, in the definition of treatments allowed to be provided by behavior analysts and other professionals with appropriate training in these treatment methods.

c. Exempt treatment-based research from these regulations to ensure ongoing, high-quality, non-biased research in autism treatment.

d. Remove the stipulation that parents must be supervised by a behavior analyst.

We welcome the opportunity to discuss our concerns with you. If this would be helpful, please contact Evelyn M. Abouhassan, DRC Senior Legislative Advocate, or Bob Giovati, SCDD Deputy Director of Policy and Planning, to arrange a meeting time.

Sincerely,

Catherine Blakemore, Executive Director
Disability Rights California (DRC)

Dr. April Lopez, Chair
State Council on Developmental Disabilities

cc: Bill Gage, Chief Consultant, Senate Business and Professions Committee
Mareva Brown, Chief Consultant, Senate Human Services Committee

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June 9, 2016

NOTICE OF PROPOSED EMERGENCY ACTION
SUBJECT: END OF LIFE OPTION ACT

The Department of Developmental Services (DDS) is proposing to adopt emergency regulations pertaining to the implementation of the End of Life Option Act.

Government Code section 11346.1(a)(2) requires that, at least five working days prior to submission of the proposed emergency action to the Office of Administrative Law (OAL), the adopting agency provide a notice of proposed emergency action to every person who has filed a request for notice of regulatory action with DDS. After submission of the proposed emergency action to OAL, OAL shall allow interested persons five calendar days to submit comments on the proposed emergency regulations as set forth in Government Code, section 11349.6. Upon filing, OAL will have ten (10) calendar days within which to review and make a decision on the proposed emergency rule. If approved, OAL will file the regulations with the Secretary of State, and the emergency regulations will become effective for one hundred and eighty (180) days. Within the 180-day effective period, the Department will proceed with a regular rulemaking action, including a public comment period. The emergency regulations will remain in effect during this rulemaking action.

Attached to this Notice is the specific regulatory language of the proposed emergency action and Finding of Emergency.

You may also review the proposed regulatory language and Finding of Emergency on the DDS website at http://www.dds.ca.gov.

If you have any questions regarding this proposed emergency action, please contact Alyssa Carroll, Staff Attorney, Department of Developmental Services, by phone at (916) 654-3405, or via email at Alyssa.Carroll@dds.ca.gov.

DEPARTMENT OF DEVELOPMENTAL SERVICES

California Code of Regulations
Title 17, Division 2
Chapter 1- General Provisions
SubChapter 10: End of Life Options Act
Article 1- General
Sections 51000, 51001, 51002

FINDING OF EMERGENCY

The proposed regulations must be adopted on an emergency basis in accordance with Government Code sections 11346.1 and 11349.6, in order to preserve public health, safety, and the general welfare. The regulations are required in order for the State Department of Developmental Services (DDS or Department) to immediately institute protocols and procedures necessitated by the enactment of the End of Life Option Act (Act), commencing with Section 443 *et seq.*, of the Health and Safety Code.

The Welfare and Institutions Code authorizes DDS to promulgate regulations. Specifically, the Legislature designated the Department with the administration of developmental centers and state-operated facilities, entities that care for persons with significant developmental disabilities. (Cal. Welf. & Inst. Code, §§ 4440, 4441, 4449, and 4484.) The statutes governing DDS also permit the Department to promulgate regulations governing the operation and training of DDS employees and others working at a developmental center. (See, Cal. Welf. & Inst. Code §§ 4449, 4485.) There is not sufficient time to promulgate these regulations through the nonemergency regulation process because the End of Life Option Act becomes effective on June 9, 2016.

INFORMATIVE DIGEST/POLICY STATEMENT OVERVIEW

The Lanterman Developmental Disabilities Services Act (Lanterman Act), commencing with Welfare & Institutions Code section 4500 *et seq.*, requires the Department to ensure the care and treatment of individuals with developmental disabilities. The individuals who require the most critical care and services under the Lanterman Act reside in developmental centers and state-operated facilities, which are under the jurisdiction of the Department.

Presently, individuals residing in the developmental centers and suffering from a terminal illness receive appropriate and necessary medical care for their condition, including counseling, hospice, and palliative care. However, effective June 9, 2016, qualified terminally ill individuals residing in a DDS facility will have the ability to seek to participate in the end-of-life activities permitted under the Act. Accordingly, it is necessary for DDS to enact regulations that provide

clear directives to employees and facility residents regarding the Department's response to the End of Life Option Act.

51000: Reiterates entitlement to treatment for terminally ill individuals residing in a developmental center or state-operated facility, and precludes DDS' employees and others acting on the Department's behalf from providing end-of-life options on DDS premises.

51001: Sets forth the procedures governing when a terminally ill individual residing in a developmental center or state-operated facility requests to exercise his or her rights under the End of Life Option Act.

51002: Identifies the appeal process for terminally ill individuals seeking to participate in end-of-life options under the Act on the premises of a developmental center when no community option is available.

OBJECTIVE AND ANTICIPATED BENEFITS OF THE PROPOSED REGULATIONS

When the End of Life Option Act goes into effect on June 9, 2016, DDS employees and others acting on the Department's behalf will be confronted with novel legislation permitting qualified terminally ill persons to participate in end-of-life options under the Act. The objectives of the proposed regulations are to create clear directives issued by DDS relating to the Department's response for those wishing to exercise their rights under the Act. These regulations articulate the procedures necessary to ensure the health, safety, and ethical treatment of the vulnerable persons residing in or committed to developmental centers and state-operated facilities. The regulations prohibit the participation in end-of-life options under the Act on premises owned or operated by DDS. They also preclude employees, independent contractors, and other persons from participation in end-of-life activities while acting within the scope of their employment or contract with DDS.

The regulations set forth protocols that articulate the authorized actions that an employee or other person may take when an individual residing at or committed to a developmental center or state-operated facility requests to exercise rights specified in the Act. The regulations provide an appeals process where the Director of DDS may authorize a person to exercise his or her rights under the Act when no community facility is available.

Benefits:

Adoption of these regulations is necessitated by the enactment of the End of Life Option Act. These regulations create a mechanism to ensure the continued safe and ethical care provided to persons residing in developmental centers, while also establishing a structure to permit individuals to exercise the rights afforded under the End of Life Options Act. The regulations